Physicians' Newsletter

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2006 Agreement with the British Columbia Medical Association

The government of British Columbia, the British Columbia Medical Association and the Medical Services Commission have signed a new six-year agreement that is effective from 2006 to 2012. Copies are available on the Ministry of Health web site at: http://www.health.gov.bc.ca/msp/legislation/bcmaagree.html.

The 2006 Agreement addresses issues in the existing 2004 Working Agreement, including increases in fees and rates. It also provides for system redesign and renewal, includes disparity adjustments among specialists and identifies a framework for a new agreements structure which includes increased input from health authorities on the negotiation of future agreements.

Implementation of the 2006 Agreement is now underway. Please visit the Ministry of Health web site for more information and to view Frequently Asked Questions on topics including the Full Service Family Practice Incentive Program, the Specialist One Time Payment and the Physician Information Technology Office. The web site also includes the new salary, service and sessional rates, effective April 1, 2006.

Fee changes will be implemented following the BCMA process to determine allocations, likely in April 2007. However, payments will be retroactive to April 1, 2006, as indicated in the Agreement.

Designated Statutory Holidays – Year 2007

Jan	01	Mon	New Year's Day
Apr	06	Fri	Good Friday
Apr	09	Mon	Easter Monday
May	21	Mon	Victoria Day
Jul	02	Mon	in lieu of Canada Day
Aug	06	Mon	BC Day
Sep	03	Mon	Labour Day
Oct	08	Mon	Thanksgiving Day
Nov	12	Mon	in lieu of Remembrance Day
Dec	25	Tue	Christmas Day
Dec	26	Wed	Boxing Day

BRITISH COLUMBIA | Ministry of Health

New and Updated Explanatory Codes

The following is a new explanatory code:

LB This item is not a benefit of the plan unless performed in an MSC approved facility or as an outpatient service.

The following explanatory codes have been reworded:

JW 01200-01202, 01205-01207 and 01215-01217 are not payable in addition to adult and paediatric critical care fees (01411-01441, 01412-01442 and 01413-01443).

IQ Refractory period is 30 minutes for non operative continuing care surcharges unless for CCFPP care.

I3 01200-01202, 01205-01207 and 01215-01217 only apply when the physician is specially called to render emergency or non-elective services.

NM The incentive for full service GP obstetrical bonus is only applicable when fee item 14104 or 14109 is paid to the same physician/same day.

OA Primary and secondary wound management fees are only applicable with fees from the orthopaedic section.

ZK A note record did not accompany correspondence code 'N' or 'B' or payee# does not match preceding C02 record.

New WCB Explanatory Codes

C7 WCB refused emergency visit is not related to an accepted WCB claim.

E4 WCB refused – ward rate differential was not authorized.

E7 WCB refused – hospital service is not authorized.

E8 WCB refused – billed acute care per diem rate not correct for payee.

E9 WCB refused – hospital service is not related to an accepted WCB claim.

M4 WCB refused your claim submission. Unable to locate employer for claim/patient. Please clarify with patient. Resubmit with revised info if WCB claim.

M5 WCB refused your claim submission. The physio stream was not authorized. If clarification is required contact WCB adjudicator.

M6 WCB refused your claim submission. The fee item is not appropriate for the WCB claim decision.

M7 WCB refused claim. Semi-private room was not billed with per diem.

M8 WCB refused claim. Physiotherapy home visit travel only paid with visit.

N1 WCB refused – long term care not paid when an acute care per diem or an emergency visit has been paid.

N2 WCB refused – cast clinic booked outpatient visit is not paid with acute care per diem unless it is the day of admission.

N3 WCB refused – medical miscellaneous take away items must be billed on the same date as an emergency visit or daycare surgery or on the day of acute care discharge.

N4 WCB refused – billing submitted more than 90 days after service rendered.

N5 WCB refused – hospital service not payable with already paid services.

N6 WCB refused – dressing change booked outpatient visit is not paid with acute care per diem unless it is the day of admission.

N7 WCB refused – sterile environment booked outpatient visit is not paid with acute care per diem unless it is the day of admission.

N8 WCB refused – ward rate differential must be billed for same date of service as acute care per diem.

WD WCB refused. WCB claim is disallowed. If clarification required contact WCB payment services department.

XW WCB refused – WCB did not receive the report. If clarification required contact WCB payment services department.

Out-of-Province Health Care Coverage

Workers and Vacationers

BC residents may be eligible to receive coverage for up to 24 months (previously 12 months) while temporarily working or vacationing outside the province. Approval is limited to once in five years for absences that exceed six months in a calendar year. As in the past, residents who spend part of every year outside BC must be physically present in Canada at least six months in a calendar year and continue to maintain their home in BC in order to retain coverage.

Individuals whose employment requires them to routinely travel outside BC and who are unsure of their eligibility for coverage should contact Health Insurance BC (HIBC).

Students

Previously those who left BC temporarily to study outside Canada could be covered for a maximum of five years. Now, coverage may be available for the duration of studies, just as it is for BC residents studying elsewhere in Canada. Students must be in full-time attendance at a recognized educational facility and be enrolled in a program which leads to a degree or certificate recognized in Canada.

Generally, beneficiaries who have been studying outside BC must return to the province by the end of the month following the month in which studies are completed. Any student who will not return to BC within that timeframe, and has been away for less than 24 months, should contact HIBC to discuss their situation.

When to Contact HIBC

BC residents who are unsure if they will qualify for coverage during a temporary absence, or know that eligibility will end, need to get in touch with HIBC.

Additional Health Insurance

The Ministry of Health strongly recommends that BC residents buy additional health insurance from a private insurer before leaving the province.

Public phone numbers for HIBC are:
604 683-7151 Vancouver
1 800 663-7100 elsewhere in BC.

Update to Billing Seminars for Medical Office Assistants

The Medical Services Branch received an overwhelming positive response from the billing seminar needs assessment sent with your last newsletter. We are now in the midst of developing the billing modules and will soon determine the dates, times and locations for the seminars. As soon as we have details to report, a broadcast message will be sent and information will be posted on the MSP web site.

We appreciate your enthusiasm, feedback and participation. For questions please call 250 952-1059.

Influenza (Flu) Immunization

A physician's recommendation for influenza immunization proves to be the most significant factor in their patient's decision to be immunized. Encourage your patients to get immunized against influenza.

Influenza vaccine is provided free to:

- Staff and residents of care facilities;
- People 65 years of age and over;
- Adults and children with chronic health conditions and their caregivers/ household contacts;
- All infants 6-23 months of age and the household contacts of all children ages zero to 23 months-of-age;
- Pregnant women in their third trimester, if they are expected to deliver during the influenza season (as they become household contacts of the newborn);
- Independent health care practitioners (e.g. doctors, nurses, and dentists) and their staff;
- Emergency responders (police, fire and ambulance workers);
- Corrections officers and inmates of provincial correctional facilities; and
- People working with live poultry and/or swine.

For a detailed listing of eligible recipients, review Section VII, page 31 of the BCCDC Immunization Manual on their website: http://bccdc.org.

Things to consider:

1) In BC, there will be two publicly funded influenza vaccine products this season: Fluviral® and Vaxigrip®
2) Vaxigrip® contains less thimerosal and may be offered to infants 6 to 23 months of age and pregnant and breastfeeding women.
3) Vaxigrip® must be used within 7 days of vial puncture; therefore to avoid wastage, administer any remaining doses in the vial to other eligible patients.

Influenza season is also an opportune time to provide the pneumococcal polysaccharide vaccine to patients. This vaccine is provided free to people 65 and over, adults and children with chronic health conditions, and residents of care facilities. Usually, only one dose of pneumococcal vaccine is required. For a detailed listing of eligible recipients and revaccination criteria, review Section VII, pages 43 and 43a of the BCCDC Immunization Manual available on their web site: http://bccdc.org.

Influenza shots should be billed under fee item 00010 (intramuscular medications) for any person eligible to receive the free vaccine. A visit fee should not be billed if the influenza shot was the sole reason for the visit.

Only those persons eligible for publicly funded vaccine should have their influenza shots billed to MSP. Charging an eligible person, for either the vaccine product or the injection is in contravention of the Medicare Protection Act Part 4 Section 17(1).

For more information on Influenza and other vaccine preventable diseases please visit the BC Health Files at http://www.bchealthguide.org/healthfiles/index.stm.

Medical Services Commission (MSC) Publications available

Two new MSC publications can be accessed on the internet. The *Medical Services Commission Financial Statement for the Fiscal Year Ended March 31, 2006* can be found at www.health.gov.bc.ca/msp/financial_statement.html and the *Medical Services Commission 2005/2006 Annual Report* is available at www.health.gov.bc.ca/msp/legislation/msc/html .

Share Billing Information with your Medical Office Assistant

Please share the billing information included in this newsletter with your office staff.

In addition, you may find it useful to file the newsletters in your office as they can be very helpful as reference material.

Repeat Laser Iridotomy

Laser iridotomy is performed by ophthalmologists to treat glaucoma and is billed as fee item 22113 laser iridotomy per eye. A repeat iridotomy may be clinically necessary in the event of a failed previous procedure. However, the fee for the repeat iridotomy performed within 30 days of a previous iridotomy on the same eye is included in the previous claim for 22113, and therefore is not payable by MSP.

Update to Guidelines

Guideline Withdrawal

Use of Homocysteine Measurement in the Evaluation of Atherothrombotic Disease

Effective December 15th, 2006.

Clinical evidence no longer supports these recommendations, and consequently the guideline is no longer of clinical relevance.

Revised Guidelines

- *Investigation and Management of Vitamin B12 and Folate Deficiency*

Effective December 15th, 2006.

This guideline supersedes the previous guideline, Investigation and Management of Vitamin B12 and Folate Deficiency, effective July 1st, 2003. This guideline will be used in the determination of benefits payable under the *Medicare Protection Act*.

- *Erythrocyte Sedimentation Rate*

Effective December 15th, 2006.

This guideline supersedes the previous guideline, Erythrocyte Sedimentation Rate, effective March, 2003. This guideline will be used in the determination of benefits payable under the *Medicare Protection Act*.

- *Investigation and Management of Iron Overload*

Effective December 15th, 2006.

This guideline supersedes the previous guideline, Investigation and Management of Iron Overload, effective September 1st, 2001. This guideline will be used in the determination of benefits payable under the *Medicare Protection Act*.

Updated List of Guidelines

A	Acute Otitis Media - Revised 2004
	Ambulatory ECG - Holter Monitor and Patient-Activated Event Recorder - Revised 2004
	Antiepileptic Drug Concentration Measurement in Adults
	Antinuclear Antibody (ANA) Testing for Connective Tissue Disease
	Assessment and Management of Obstructive Sleep Apnea in Adults – Revised 2005
B	Bone Density Measurement in Women – Revised 2005 | ✔ Patient Guide
C	Chest X-rays in Asymptomatic Adults Guideline, Tuberculosis Screening and Patient Guide removed - outdated and no longer in effect
	Cholesterol Testing: Adults Under 69 Years Guideline, Quick Reference and Patient Guide removed - outdated and no longer in effect
	Chronic Obstructive Pulmonary Disease (COPD) | ✔ Patient Guide
	Clinical Approach to Adult Patients with Dyspepsia – Revised 2004
	Clinical Approach to Adult Patients with Gastroesophageal Reflux Disease – Revised 2004
	Clinical Management of Chronic Hepatitis B - Revised 2004 | ✔ Patient Guide
	Clinical Management of Chronic Hepatitis C - Revised 2004 | ✔ Patient Guide

D
Detection and Diagnosis of Hypertension (Part I) | ✔ Patient Guide
Detection and Treatment of Helicobacter pylori Infection in Adult Patients - Revised 2003
Detection of Colorectal Neoplasms in Asymptomatic Patients | ✔ Patient Guide
Detection of Drugs of Abuse in Urine: Methadone Maintenance Program
Diabetes Care - Revised 2005 | ✔ Patient Guide | ✔ Flow Sheet
Diagnosis and Management of Asthma | ✔ Patient Guide
Diagnosis and Management of Major Depressive Disorder | ✔ Patient Guide
Diagnosis and Management of Sore Throat - Reviewed 2003

E
Electrocardiograms - Reviewed 2003
Erythrocyte Sedimentation Rate - Reviewed 2003
Evaluation and Interpretation of Abnormal Liver Chemistry in Adults
Evaluation of Acute Chest Pain for Acute Coronary Syndromes

F
Follow-up of Patients after Curative Resection of Colorectal Cancer - Revised 2004

H
Heart Failure Care | ✔ Patient Guide | ✔ Flow Sheet
House Calls Protocol rescinded October 2003 - now included in MSC Payment Schedule Preamble B.4.g.
Hematology Profile in Adults Guideline removed - outdated and no longer in effect

I
Identification, Evaluation and Management of Patients with Chronic Kidney Disease | ✔ Patient Guide
Initiation and Maintenance of Warfarin Therapy | ✔ Patient Guide | ✔ Patient Record Sheet
Investigation and Management of Vitamin B12 and Folate Deficiency
Investigation and Management of Iron Deficiency - Revised 2004
Investigation and Management of Iron Overload
Investigation of Metastatic Bone Disease in Newly Diagnosed Prostate Cancer Using Nuclear Medicine Techniques - Reviewed 2003
Investigation of Suspected Infectious Diarrhea - Reviewed 2003
Investigation of Suspected Osteomyelitis in Normal Bone Using Nuclear Medicine Techniques Reviewed 2003

M
Macroscopic and Microscopic Urinalysis and Investigation of Urinary Tract Infection - Reprinted 2004
Management of Warfarin Therapy During Invasive Procedures and Surgery | ✔ Patient Guide
Microscopic Hematuria (Persistent)

O
Office and Laboratory Management of Genital Specimens
Otitis Media with Effusion - Revised 2004
Ova and Parasite Testing of Stool Samples - Reviewed 2001 (Reprinted 2003)
Overweight, Obesity and Physical Inactivity | ✔ Patient Guide

P
Prenatal Cytogenetic Testing Guideline removed - outdated and no longer in effect
Prenatal Ultrasound Guideline, Quick Reference and Patient Guide removed - outdated and no longer in effect
Preoperative Testing - Reviewed 2003
Primary Care Management of Sleep Complaints in Adults - Revised 2004

R
Rheumatoid Arthritis: Diagnosis and Management | ✔ Patient Guide

T
Thyroid Function Tests in the Diagnosis and Monitoring of Adults with Thyroid Disease - Revised 2004
Treatment of Cataract in Adults - Revised 2005 | ✔ Patient Guide
Treatment of Essential Hypertension (Part II) | ✔ Patient Guide | ✔ Flow Sheet
Treatment of Gallstones in Adults - Revised 2001 | ✔ Patient Guide
Treatment of Patients Overanticoagulated with Warfarin | ✔ Patient Guide

U
Use of Diagnostic Facilities for Mammography | ✔ Patient Guide
Use of Glucose and HBA 1c Tests in Diagnosis and Monitoring of Diabetes Mellitus Guideline removed - outdated and no longer in effect
Use of Hematology Profile in Adults Guideline removed - outdated and no longer in effect
Use of Homocysteine Measurement in the Evaluation of Atherothrombotic Disease

V
Viral Hepatitis Testing - Revised 2005

X
X-ray for Acute Ankle Injury - Revised 2002

Health Insurance BC
Changes to the MSP Phone and Fax Numbers

Reminder

The summer newsletter posted information on the retirement of Ministry of Health phone and fax numbers. This has been done in an effort to consolidate and simplify the Health Insurance BC (HIBC) MSP numbers. An MSP Provider Phone Number Insert was included with the summer newsletter highlighting the numbers to be retired and the corresponding HIBC phone and fax numbers now in effect.

Improvements have also been made to the HIBC MSP telephone menu. A single point of access is now available for Health Care Providers through a Lower Mainland local phone number and toll-free access for the rest of British Columbia.

The following MSP Phone Numbers are now retired. Please make note of the new HIBC numbers replacing the Ministry of Health numbers. Also note that Teleplan Support no longer has a separate phone number. To reach Teleplan Support through the new telephone menu system, at the main menu:

- press 3 for Provider Services
- then press 2 for Teleplan

Follow the menu prompts to reach other areas in MSP.

Please take a moment and confirm you are now using the HIBC phone and fax numbers. We also ask that you dispose of any forms or other HIBC correspondence you have on file containing the retired phone numbers.

PROVIDER		NEW NUMBER	RETIRED NUMBER
Providers Telephone Menu	Tel:	604-456-6950 – Lower Mainland	250-952-2654
	Tel:	866-456-6950 – Rest of BC	
Teleplan	Tel:	604-456-6950 – Lower Mainland	250-952-2668
	Tel:	866-456-6950 – Rest of BC	800-663-7206 – Toll-Free
Provider Programs	Fax:	250-405-3592	250-952-3101
Adjudication	Fax:	250-405-3591	250-952-3051
Benefit Services	Fax:	250-405-3593	250-952-3222
Cosmetics	Fax:	250-405-3590	250-952-3032
Out of Country	Fax:	250-405-3588	250-952-2964

Travel Medicine Services

Physicians should note that travel medicine services such as providing advice, prophylactic prescriptions or vaccinations which are usually obtained from specialized travel medicine clinics are not a benefit. A visit mainly for the purpose of assessment and treatment of a pre-existing condition, such as a stroke or myocardial infarction, would remain a benefit prior to travel if the visit was a part of patient's expected care, regardless of travel intentions. Likewise, 00010 injections are always billable for universal immunizations such as tetanus or polio, and may be selectively billable for vaccinations such as Hep B or influenza, administered to designated high risk patients in accordance with BCCDC guidelines. Physicians are referred to the BCCDC web site for the most current vaccination guidelines (see http://www.bccdc.org).

Travel Assistance Program – Your Role in Helping Patients Obtain Care away from Home

The Travel Assistance Program (TAP) was introduced in 1993 to help mitigate the cost of travel for patients who must travel to obtain non-emergency specialist care outside their home community. Like many successes, TAP bears the burden of its own popularity. Ferry travel accounts for the majority of TAP travel, particularly for residents living on more remote islands and coastal areas of the province. Travel volumes have risen dramatically in the past five years and costs have risen even more. Needless to say, this puts tremendous pressure on the travel program.

We would like to take this opportunity to thank physicians and their staff for willingly participating in this valuable program. We also want to remind you of the important role you play in ensuring that travel assistance is used efficiently so that benefits under this program are available when your patients need them.

The report issued by the Office of the Comptroller General, following a recent audit of TAP, recommends that program controls be strengthened to ensure only eligible costs related to ferry travel are charged to the program.

Since the program relies heavily on referring physicians to administer TAP policy correctly, we request your cooperation in ensuring that Part 1 of the TAP form is fully and accurately completed in the office, including the "Escort Required" field, that the form is signed and/or stamped only at the time it is issued, and that multiple forms are not issued or made accessible to your patients.

Please review the following policies and procedures before issuing a TAP form:

Eligibility

- The patient must be a B.C. resident, enrolled in MSP.
- The patient's medical travel expenses are not covered by a third-party insurance plan, such as employer plans, active ICBC, Workers' Compensation or Department of Veterans' Affairs, Canadian Armed Forces, or other federal government programs.
- The program is not intended for patient transfer from one facility to another.
- GP to GP referrals are not eligible for TAP.
- Supplementary benefit practitioner services (e.g., optometry, physical therapy, massage therapy, podiatry, dentistry, naturopathy, and chiropractic services) and non-insured services (e.g., cosmetic surgery, experimental procedures, clinical drug trials, preventative medicine) are not eligible for TAP.
- Meals, accommodation, fuel and local transportation expenses are not included in TAP.

Physicians are also asked to consider the services offered by local, regional, and traveling specialists to help ensure that patients benefit from these services before travelling outside their communities.

Approving Travel Assistance

Referrals should be made to the specialist practising in the nearest location to the patient's home community.

Physicians or their office staff should completely fill out Part 1 – Physician's Referral form, including the Yes or No box for "Escort Required", and ensure the form is properly signed or stamped. Transportation partners have the right to refuse an incomplete or altered TAP form.

Please note the following policy regarding patient escorts:

- An escort is eligible only when accompanying a patient who is: (1) 18 years of age or under; or (2) is incapable of travelling alone due to medical condition.
- An escort is not eligible when driving a vehicle on behalf of a patient who does not fall under (1) or (2) above; or when travelling alone to pick up a patient.

An approval form should be provided to the patient only at the time of making the referral. Multiple forms should not be provided at one time, and blank forms should not be accessible to patients. Patients who must make repeat visits to the same specialist for the same course of treatment can obtain additional TAP forms from their specialist at the time that their next visit is scheduled.

Program Benefits

- BC Ferries: 100% discount for patient, vehicle, and escort (see policy previous page).
- Harbour Air: 30% discount on regular economy air fares.
- Hawkair: Special medical fares are special fares that do not require advance booking, allow change of travel dates without change fee, are refundable, and can be booked for an open return.
- Helijet: 30% discount on full economy fare for flight between Victoria and Vancouver Harbour or Vancouver Airport.
- North Pacific Seaplanes: 30% discount on air travel in Prince Rupert/Queen Charlottes area. Central Mountain Air: Regular fare discounted and some flight restrictions waived.
- Angel Flight: Provides free air transport for ambulatory people who, due to their medical condition, cannot travel by conventional means –to and from points on Vancouver Island and Lower Mainland.
- VIA Rail: 30% discount.
- Pacific Coach Lines: Deducts the ferry fare from the ticket price on travel between Victoria and Vancouver. Also provides free bus transportation for cancer patients requiring care at the Vancouver Cancer Centre.
- Malaspina Coach Lines: Deducts the ferry fare from the ticket price on travel between Powell River and Vancouver.

Note:
Applicants presenting incomplete or altered forms, or forms without a valid TAP confirmation number will be refused discounts. Patients are responsible for making their own travel and accommodation arrangements.

Need TAP forms?

Physicians can have TAP forms sent to their office by calling HIBC Provider Services at:
1 866 456-6950 (toll free) or
604 456-6950 for the Greater Vancouver area.
Press 3, then press 5. This automated line will connect you to a client service representative.

TAP forms can also be ordered by faxing your request to: HIBC Provider Services at 250 405-3592. Be sure to include your name, mailing address, and MSP Practitioner Number with your faxed request.

Important Information for Physicians with Palliative Care Patients

Effective April 2005, a new fax number for Palliative Care Benefits Program Applications was introduced. Please ensure all applications are faxed to 250-405-3587.

If your current supply of forms states any other fax number, please order updated forms by:

- faxing a request to 250-952-4559, or
- sending an e-mail to james.mcgarry@gov.bc.ca
- downloading or completing a form online at www.health.gov.bc.ca/pharme/outgoing/palliative.html.

A Physician Guide and patient information sheet are also available by visiting the PharmaCare website address provided above.

Methylphenidate

In May 2006, a provincial Order in Council was approved allowing methylphenidate to be prescribed and dispensed without a Controlled Drug Program prescription (formerly known as the Triplicate Prescription Program). Therefore, this drug no longer requires use of the duplicate prescription pad. PharmaNet has been updated to allow normal processing of these prescriptions by all registered practicing physicians*.

*Any restrictions placed on individual practitioners by the College of Physicians & Surgeons of BC remain in effect.

Update of Medical Practice Access to PharmaNet (MPAP)

Since the launch of province-wide MPAP in December 2005, over 930 physicians have elected to connect to PharmaNet.

For more information on the benefits of access to patient PharmaNet medication profiles at the point of care, how to connect, visit the Ministry of Health's Data Access Services MPAP web page at www.health.gov.bc.ca/ehealth/das/medpract.html or send an e-mail to HLTH.DataAccessServices@gov.bc.ca.

eHealth and PharmaNet
Building Towards Electronic Health Records for BC Residents

PharmaNet, the province-wide computer network linking pharmacies and other health care sites to a central Ministry of Health database, provides prescription claim processing and clinical drug information to authorized health care providers across the province. This tool, used by B.C. community pharmacists every day and recognized worldwide for its capabilities, will be significantly upgraded as part of the B.C. eHealth initiative.

What is eHealth?

The provincial government's eHealth Strategic Framework sets out a group of initiatives and investments that will integrate electronic patient records and connect pharmacists, doctors, and other health care providers to new secure, shared, Electronic Health Records (EHRs). This will include upgrading the existing PharmaNet system to include more comprehensive patient medication profiles. The new eHealth program is supported by significant investments from Canada Health Infoway (Infoway) which assists provincial projects that further the goal of creating EHRs for 50 per cent of Canadians by the end of 2009. B.C. has one of the most comprehensive suites of eHealth projects underway. These projects are cooperatively funded and the approach and architecture conform to the Infoway blueprint for pan-Canadian EHR systems and standards.

How will eDrug affect PharmaNet?

Significant enhancements to PharmaNet will play a key role in the eHealth initiative. The eDrug project, part of the eHealth initiative, will augment PharmaNet's capabilities, allowing it to more fully support the work of pharmacists and physicians in a variety of clinical settings.

Improvements to PharmaNet will be designed to improve patient safety, enhance decision-making, improve coordination and delivery of care, and promote better cost management. For instance, prescribers will be able to enter prescriptions directly into PharmaNet and pharmacies will be able to retrieve the e-prescriptions for dispensing. As well, the recording of prescription pickup by the patient will yield more accurate medication profiles and allow more proactive monitoring of compliance. The profiles will also be updated when a patient is discharged from hospital, with a summary of relevant medications and any updates to clinical conditions. The eDrug project will also make it possible for individuals to access their own PharmaNet medication records online.

Will the privacy of B.C. residents continue to be protected?

Yes. As noted in the eHealth Strategic Framework, every eHealth project will place the utmost importance on the protection of personal health information and will comply with provincial government requirements. eDrug will build on PharmaNet's leadership in privacy protection and accountability to the public.

In addition, to ensure system security and protect against unlawful access or malicious tampering, every effort will be made to ensure access is absolutely restricted to only those having a clear right and need to access personal health information or to access the systems within which personal information resides. The transmission of information will be fully safeguarded from accidental or intentional interception and unauthorized users.

Who is involved in the eDrug project?

The College of Pharmacists of B.C., the College of Physicians and Surgeons of B.C., the B.C. Pharmacy Association and the B.C. Medical Association are key stakeholders and are working with the Ministry of Health/Pharmaceutical Services on the eDrug project. Each actively participates in the eDrug Steering Committee and eDrug Clinical Working Group, providing direction, insight and guidance on the development and implementation of the enhanced system.

What activities are currently underway?

The eDrug project recently received funding approval from Canada Health Infoway for integration and implementation of the new system. In the months to come, eDrug project representatives and the Ministry of Health's Pharmaceutical Services Division will be working with pharmacists, physicians, and other stakeholders to identify potential enhancements and refine specific system requirements.

Throughout the fall and winter, task groups will meet to review specific issues identified by the eDrug Clinical Working Group. For example:

- The Health Authority Task Group has been initiated to advise and recommend the hospital system medication information that should be integrated with PharmaNet.
- The Drug Information Reference Task Group will review and make recommendations on business requirements for the drug information data base that will support eDrug implementation in BC. It will also identify potential Drug Information Reference vendors.
- The Compliance Task Group will contribute to and review compliance specifications and processes for 'point-of-service' software vendors.

When will the new PharmaNet system be deployed?

It is expected that the new PharmaNet system will be phased in beginning in early 2008. Community pharmacies will be the first group to connect to the new system.

Where can I get more information on eHealth and eDrug?

For more information, or to view or download a copy of the eHealth Strategic Framework, visit: www.health.gov.bc.ca/ehealth/index.html.

Additional information about the plans and activities for PharmaNet expansion can be obtained by contacting edrug@gov.bc.ca.

Updates will be issued as the project progresses.

Close-Off Dates 2007

January	04	May	04	September	05
January	22	May	22	September	19
February	06	June	06	October	03
February	19	June	20	October	22
March	06	July	04	November	05
March	21	July	20	November	21
April	02	August	03	December	05
April	19	August	22	December	18

Audit Reports

The following audit reports are reprinted as they appeared in the original settlement agreements.

Dr. A.

A GP came to the attention of the Billing Integrity Program (BIP) as a result of a routine service verification survey in which beneficiaries reported irregularities in respect to counselling, callout charges and injections. A review of the practitioner's billing profile revealed that the practitioner's total personal costs per patient were 142% higher than the group average, and could not be explained by subsequent case-mix analysis which adjusts costs for patient morbidity. A peer medical inspector found missing and inadequate records, missing appointment books, incorrect billing for counselling, complete physical examination, call-out charges, 3rd party and other uninsured services. Many claims were also for services rendered by the practitioner's partner and were submitted with the wrong practitioner number.

As a result of a mediated settlement, the physician agreed to repay the Medical Services Commission (MSC) $200,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule.

Dr. B

A general practitioner engaged in full time emergency medicine practice was audited by the MSC because of an unusually high cost per patient, stemming directly from a disproportionately higher rate of Level II and III Emergency Care billings. A medical peer inspected a representative sample of the physician's records and found that some visits were payable as lesser levels of care. For example, Level III was claimed for assessment of an uncomplicated post-ictal patient with a known seizure disorder.

As the result of a negotiated settlement, the physician agreed to repay the MSC $19,100 inclusive of costs and interest and comply with a pattern of

practice order in which the physician would comply with the Emergency Medicine Preamble in respect to criteria for levels of complexity of care and maintain adequate, medical records.

Dr. C - Dr. Pradeep K. Vohora
Dr. Vohora was reported to the Medical Services Commission (MSC) by the College of Physicians and Surgeons of British Columbia (College) in 2003, following his admission of infamous conduct and subsequent resignation from the College. Dr. Vohora was known to the Billing Integrity Program after a previous audit and recovery in 1988. The MSC's Audit and Inspection Committee (AIC) ordered another on-site audit, which found billing errors in respect to: services not rendered; uninsured services; delegation of counselling to a psychologist; and billing 0100-series office visits in lieu of 00039 methadone maintenance or 00010 injections. Dr. Vohora had also submitted claims for visits in which prescriptions were provided to undercover police officers for controlled narcotics, in the absence of a medical need.

As a result of a negotiated settlement, Dr. Vohora agreed to repay the MSC $20,000, including audit costs and interest. Furthermore, in the event that he successfully reapplies for medical licensure and enrollment with the MSP, he must comply with a pattern of practice order in which he will prepare and maintain adequate medical records, obey the *Medicare Protection Act* and regulations and the MSC Payment Schedule in all respects, and may be subjected to a further on-site audit, ordered at the discretion of the AIC.

Dr. D.
An internal medicine specialist came to the attention of the Commission as the result of a Service Verification Audit which indicated that the physician had billed the Plan for office visits and counselling in respect to ambulatory blood pressure monitoring (ABPM), which is not a benefit. An on-site audit was ordered, and the peer medical inspector found that the physician had prematurely destroyed many medical records and appointment books in the process of relocating offices, and billed visits and counselling for the purpose of rendering ABPM. The physician also billed 00314 prolonged visit for counselling on patients with multiple medical problems, but where the discussion constituted the advice that would be the normal component of an office visit, or pertained to lifestyle issues, and did not involve significant emotional distress.

As the result of a negotiated settlement, the physician agrees to repay the Commission $220,000, and abide by a pattern of practice order in which ABPM-related services would not be billed to the Plan, adequate medical records and appointment books would be prepared and maintained, and counselling fee items would be billed in accordance with the MSC Payment Schedule.

Clarification - Labelling Pap Tests

The BC Cancer Agency has recently informed MSP that a significant number of requisitions arrive at their lab without the physician's information clearly stamped on the form. This results in a delay providing test results to physicians. Please ensure that each requisition is clearly stamped with the physician's information when submitting to BCCA for testing to ensure test results are not unnecessarily delayed.

Billing for Unregistered Newborns

If a newborn has not been registered with the Medical Services Plan (MSP), services can be billed under the mother's personal health number (PHN) using dependent number 66.

The maximum period during which MSP will cover an unregistered baby under the mother's PHN is the month of birth plus the following two months.

Diagnostic Facility Services

We wish to remind you of the introduction of a new broadcast service. Diagnostic Facilities now receive a broadcast message 45 days prior to the expiry date of a practitioner/facility connection when the existing connection is of a duration that is 6 months or greater.

Facilities should be aware that requests for exemption from the 90-day limit on accounts will no longer be granted because of administrative oversight in renewing assignments.

Updated Protocol for Planned Home Deaths now Available

The Protocol

Many Canadians would like to die at home. Since 1996, British Columbia has been using a planning document called the Joint Protocol for the Management of Planned Home Deaths to support individuals in this choice. The Protocol instructs individuals at the end of their lives, their families, and health care professionals in how to manage anticipated natural home deaths.

While the 1996 Protocol has been successful in directing families, first responders, and health care providers in planning for home deaths and responding appropriately at the time of death, ten years of experience with the document led to its review and the identification of areas requiring additional clarity. In 2004, the Fraser Health Authority, with support from the Ministry of Health, initiated a process to review and revise the Protocol. This work is now complete and has resulted in a revised document entitled Joint Protocol for Expected/Planned Home Deaths in British Columbia (2006) that brings greater clarity to roles, responsibilities, and activities involved in a home death.

Notification of Expected Death: A New Option That Can Relieve Family Stress

The most significant change in the document focuses on the pronouncement of death by a physician or nurse prior to the removal of a body. It is widely recognized that it is sound clinical and ethical practice for physicians and nurses to be available to support expected death in the home, including pronouncing death. While the pronouncement of death is the usual procedure, BC law does not require it. On the other hand, funeral directors in BC require either pronouncement or assurance that the death was expected before they will remove the body. There are situations when death occurs at night or in a remote area leaving families waiting for some time after the death before a physician or nurse arrives to pronounce death and the funeral home removes the body. In these situations, the requirement to wait hours for pronouncement can be very stressful for families.

The new Protocol addresses such circumstances with the introduction of a new form called Notification of Expected Death. This form is a communication tool between the family and the physician and a funeral home prior to death. The Notification of Expected Death documents the family's decline of a pronouncement of death, the physician's assurance that the death was expected and planned, the physician's agreement to sign the Medical Certification of Death, and the written authorization from the person with the right to control disposition of the body.

Through discussion with the physician about how death in the home will be managed, a family may now choose to decline a pronouncement of death. The Notification of Expected Death is then completed by family and physician and conveyed to the funeral home, and the family is instructed to follow certain procedures at the time of death: to note the time of death, wait at least one hour after breathing has stopped, and to call the funeral home when they are ready to have the body removed.

Completing a Notification of Expected Death is not meant to replace pronouncement of death if families want it, but to provide an option when obtaining pronouncement is difficult or seen as unnecessary by the family. A visit after the death can be comforting to families and therefore should be considered by the physicians and nurses caring for them.

Families may change their minds as death approaches and decide that they wish to have death pronounced rather than use the Notification of Expected Death form. If this is the case, the family would wait until a physician or nurse is available to come to the home to pronounce death.

No CPR Order

A further change to the Protocol is in its references to a No Cardiopulmonary (CPR) Order rather than to a Do Not Resuscitate (DNR) Order. The new form uses the current, more precise nomenclature of the revised Ministry of Health form HLTH302.1 Rev 2003/05/01, used by individuals and their physicians to indicate that they do not want resuscitation attempted if their breathing or heart stops.

Continued next page...

Other Changes

Other changes to the document include the clarification that when the physician has concerns regarding the potential manner of the anticipated death, the physician should plan to pronounce death at home and involve the Coroner's office if appropriate. The Protocol includes an excerpt from Section 9 of the Coroner's Act that defines what is considered an unexpected or suspicious death and thus must be reviewed by the Coroner. In addition, the Protocol clarifies that the Cremation, Interment and Funeral Services Act requires funeral homes to receive authorization to remove human remains and that they receive this authorization from the correct individual.

A Successful Collaborative Effort

The Protocol is the result of the collaborative efforts of the Ministry of Health, regional health authorities, BC Ambulance Services, the Office of the Chief Coroner, BC Medical Association, BC College of Physicians and Surgeons, BC Hospice/Palliative Care Association, College of Registered Nurses of BC, Funeral Service Association of BC, RCMP "E" Division, BC Care Providers Association, (former) BC Health Association, and BC Municipal Police Chiefs Association.

Case Studies

Mrs. R. is an 86 year-old woman whose health has been steadily declining due to ischemic heart disease and a stroke two years ago. She hopes to die at home surrounded by her family but lives in a rural area. During a home visit, Mrs. R.'s physician explains about the Notification of Expected Death; the family agrees, the form is completed, and Mrs. R. remains at home until death when her family contacts the funeral home directly several hours after death has occurred. Hospital admission is avoided and the family is satisfied with the care and support they have received.

Mr. D. is a man who lives alone in a rooming house. He has no family contacts and is adamant that he would prefer to die at home. As he is without family or legally-appointed representative to assume responsibility for disposition of the body after death, the Notification of Expected Death Form cannot be completed. His home support agency is concerned about this planned home death and recognizes that pronouncement must occur as there is no one authorized to arrange for the disposition of the body. The home support worker who is with Mr. D. when he dies calls her supervisor to report the death, a physician comes to the home to pronounce death, and the Office of the Public Guardian and Trustee, which has been involved prior to the death, is contacted to arrange for transport of the body.

Although Mr. Y. has been deteriorating for some time, his family cannot come to terms with his approaching death and he is no longer able to communicate his wishes. The palliative care team plan for a pronouncement of death as they recognize that the family may need the physician to clarify the circumstances of death and reassure them about what has occurred.

Ms. L is receiving end-of-life care in her parents' home. When her parents learn that no doctor or nurse will be available to come to the home if their daughter dies during the night, they decide that if this occurs they are comfortable waiting until morning for the home care nurse to arrive. The physician and home care nurses plan and communicate regarding the future need for a pronouncement of death.

More Information

Copies of the Joint Protocol For Expected/Planned Home Deaths in British Columbia (2006), Notification of Expected Death, and No Cardiopulmonary (CPR) Order forms are available at the Ministry of Health's End-of-Life Care website at: www.healthservices.gov.bc.ca/hcc/endoflife.html

List of Inserts

- Conversation on Health – Registration Form
- Update to the Payment Schedule
- Wording Modified for Fee Items 14015 and 14016

Specialist One-Time Incentive Payments

You are eligible for the Specialist one-time incentive payment if:

- You are a Certificant or a Fellow of the Royal College of Physicians and Surgeons of Canada and/or recognized by the College of Physicians and Surgeons of British Columbia in that particular specialty.
- Practiced during the 2005/2006 fiscal year.
- Your eligible earnings are determined by the sum of 2005/2006 gross earnings from MSP fee for service, Rural Retention Premiums, Salary, Sessional or Service Contract payments from MSP or Health Authorities, Disability or Maternity Benefits.

If you meet all of the criteria submit your claim as follows:

In the fee item field
78700-$2700.00 if your gross eligible earnings are over $100,000.00
78701-$1350.00 if your gross eligible earnings are $50,000.00 to $100,000.00
78702-$675.00 if your gross eligible earnings are less than $50,000.00

In the patients PHN# field: 9808909755
In the last name field: Specpayment
In the first initial field: T

If you require a date of birth use: March 6, 1990
For date of service use: October 15, 2006
Report the diagnosis as V68
V68 is the ICD9 code for "Encounters for administrative purposes"

Due to processing limitations, the payment of most electronically submitted claims were made over three payment periods from October 30 to November 30, 2006. Claim card submissions will be paid on remittance statements between December 15, 2006 and February 15, 2007. Please do not enquire when you will receive your payment until after February 15, 2007 unless you have received a refusal and need clarification.

If you have not submitted a claim on your personal payee number recently, you may want to contact Provider Programs (phone number below) to update your address and direct bank deposit information to ensure payment is received.

For these fee items only – claim cards or facsimile should be sent to:
Ms. S. Power
Director, Medical Services Operation and Policy
3-1 1515 Blanshard St. Victoria BC V8W 3C8

Further information about the specialist one-time payment including claim card billing instructions is available at: http://www.health.gov.bc.ca/msp/legislation/bcmaagree.html or on the BCMA website at: http://www.bcma.org/public/

To update your address or direct bank deposit information call Provider Programs or for billing questions call Claims Billing Support.

Vancouver	604 456-6950
Rest of the province	1 866 456-6950

For more information concerning the agreement or eligibility criteria call the BCMA at:

Vancouver	604 736-5551
Rest of the province	1 800 665-2262

Addition of three new fee items to Coordinate Payment of the One-Time Specialist Physician Funding

The Medical Services Commission supports the addition of three new fee items to coordinate payment of the One Time Specialist Physician Funding in accordance with Section 6.5 of the 2006 Agreement between the Government of British Columbia and the British Columbia Medical Association.

G78700	Specialist one-time incentive payment where gross earnings are over $100,000.00	$2,700.00
G78701	Specialist one-time incentive payment where gross earnings are $50,000.00 to $100,000.00	$1,350.00
G78702	Specialist one-time incentive payment where gross earnings are less than $50,000.00	$675.00

Notes:

Fee items have been added with the "G" prefix to identify payment is not funded from the physicians' Available Amount.

Specialist physicians are eligible for one payment only, regardless of whether the physician is recognized in more than one speciality.

Eligibility Criteria:

i) Certificant or a Fellow of the Royal College of Physicians and Surgeons of Canada and/or be so recognized by the College of Physicians and Surgeons of British Columbia in that specialty. Specialist must have practiced during the 2005/2006 fiscal year

ii) Eligible earnings are determined by the sum of 2005/2006 gross earnings from Medical Services Plan's (MSP) fee for service, Rural Retention Premiums, Salary, Sessional or Service Contract payments from MSP or Health Authorities, Disability and/or Maternity Benefits.

Billing information:

Billable on PHN# 9808909755 only
Patient name: T. Specpayment
Birthdate: March 6, 1990
Date of Service: October 15, 2006
Diagnostic code required: V68

BRITISH COLUMBIA
The Best Place on Earth

Conversation On Health

REGISTER NOW FOR THE CONVERSATION

The Conversation on Health is about gathering British Columbians' views on health to help government make future decisions on our health system within the Canada Health Act.

Front line health workers, their professional associations, health organizations and administrators, patients, First Nations groups and other interested parties are invited to join professional meetings in communities across B.C. to discuss health topics of particular interest.

WOULD YOU LIKE TO PARTICIPATE IN A PROFESSIONAL MEETING?

☐ **YES**

☐ **NO**

PROFESSION (please fill in): _____

NAME: _____ **ADDRESS:** _____

COMMUNITY: _____ **POSTAL CODE:** _____

EMAIL: _____ **PHONE NUMBER:** _____

YOUR VIEWS ARE IMPORTANT TO US:

By filling out this form, you can participate in the Conversation on Health by expressing your views, asking questions and proposing solutions. Your input will be recorded and taken into account in future decisions on health and health care in BC. Your comments will be kept confidential and information collected will be used for planning purposes only. Completed forms can be faxed to Conversation on Health at 250 952-1390 or sent by mail to the address below.

COMMENTS: Please use the back of this form if you need more space.

SIX WAYS TO JOIN THE CONVERSATION ON HEALTH

1. **Participate in a regional forum**. To volunteer, call the toll-free Conversation on Health phone line or sign up on the Web site.
2. **Provide** feedback on the Web site: www.BCConversationonHealth.ca
3. **E-mail**: ConversationonHealth@Victoria1.gov.bc.ca
4. **Call** the Toll-free phone line: 1-866-884-2055 between 8 a.m. – 8 p.m., Monday to Friday. Translation services are available in 130 languages.
5. **Contact** your MLA.
6. **Mail** a letter to: Ministry of Health, Conversation on Health, 5-3, 1515 Blanshard Street, Victoria, B.C. V8W 3C8

BRITISH COLUMBIA
The Best Place on Earth

Update to the Medical Services Commission
Payment Schedule

General Services

Amendment

The following listings are hereby added to the list of items eligible for a major tray fee (00090):

00373	Colonoscopy with flexible colonoscope: - biopsy
00374	Colonoscopy with flexible colonoscope: - removal polyp
07464	Sigmoidoscopy, flexible; diagnostic – with removal of polyp(s) (operation only)
70547	Oesophagogastroduodenoscopy, including collection of specimen(s) by brushing or washing: - with band ligation of oesophageal varices (includes endoscopy) (operation only)

General Practice

Amendment

The following items are effective on a temporary basis from August 1, 2006 until January 31, 2009. On January 31, 2009 and after review by the British Columbia Medical Association, a recommendation may be made to remove the temporary status:

T12148 Sub-acute hospital visit $31.31

Notes:

i. Payable only when provided to patients who have had an acute medical or surgical episode and have been transferred from an acute care facility to a sub-acute care facility.

ii. Payable 2 times per patient, per week. In higher acuity situations, a note record explaining the medical necessity is required if additional visits are necessary.

iii. Not payable with 00108, 13108, 00128, 13128, 00127, 13127, 13148, 00112, 00109, 00114, 13114 or 00115.

T13148 Sub-acute hospital visit – 1st visit of the day $62.62

Notes:

i. Payable only for first patient seen in a sub-acute facility on any calendar day.

ii. Not payable on the same day to the same physician as 13108, 13114, 13127 or 13128 unless provided in a discrete facility which is in a separate geographic location from the acute care or extended care facility.

iii. Not payable on same day to same physician for the same patient in addition to 00108, 00109, 00112, 00128, 13108, 13127, 13128, 12200, 13200, 16200, 17200, 18200 and 13114 except as set out in notes iv) and v).

iv. *Essential non-emergent additional visits to a patient in a sub-acute facility by the attending or replacement physician during one day are payable under fee item 12148. The claim must include the time of each visit and a statement of need included in a note record. For daytime emergency visit, see fee item 00112.*
v. *Fee items 12200, 13200, 16200, 17200, 18200 are payable for additional sub-acute hospital visits, same day, same patient when the attending physician or replacement physician is specially called back due to a change in the patient's condition which requires the physician's attendance or due to a condition unrelated to the hospitalization. The claim must include the time of service and an explanation for the visit included in the note record.*
vi. *Sub-acute hospital visits on other than the first visit of the day remain payable under 12148.*

Anesthesia

Amendment

The following anesthetic intensity and complexity levels for the indicated interventional Radiology fee items are hereby added as follows:

P10906	Image-guided percutaneous vertebroplasty – first level	$325.00 Anes.Level 4
P10907	- each additional level (to a maximum of 3)	$75.00 Anes.Level 4

Notes:
i) Payable only when rendered on in-patient or day-care basis in acute care facility;
ii) Payable for osteoporotic fractures only if conservative therapy shows no or minimal improvement after 4-6 weeks and pain remains incapacitating;
iii) Includes all associated diagnostic imaging, including post procedural CT scan necessary to complete the procedure;
iv) Interventional Radiology consultation not payable in addition.

P10904	Percutaneous transcatheter arterial chemo-embolization (TACE)	$325.00 Anes.Level 3

Notes:
i) Fee is per session/sitting, regardless of number of lesions treated;
ii) Includes all associated imaging necessary to complete procedure;
iii) Interventional Radiology consultation is payable.

P10908	Percutaneous image-guided tumour ablation – first lesion	$432.00 Anes.Level 3

Notes:
i) Payable only for non-resectable liver, kidney, lung tumours, colorectal metastases and osteoid osteoma;
ii) Payable to a maximum of 3 lesions treated at same session – 100% for first lesion, 75% for second lesion and 25% for third lesion;
iii) Includes all CT and ultrasound guidance necessary to complete the procedure;
iv) Paid at 50% if repeated within 30 days;
v) Interventional Radiology consultation is payable.

P10909 Percutaneous intravascular/intracorporeal medical device/foreign body removal
$350.00
Anes.Level 3

Notes:

i) All angiography, angioplasty and/or intravascular stenting included;
ii) If a second or third medical device /foreign body is removed, payable at 50% each, to a total maximum of three;
iii) Interventional Radiology consultation is not payable.

P10911 Selective salpingography/fallopian tube recanalization (FTR) $350.00
Anes. Level 2

Notes:

i) Hysterosalalpinogram not payable in conjunction with the procedure;
ii) Paid at 2/3 of the fee if unilateral;
iii) FTR is not an insured benefit when used to correct scarring of the fallopian tubes after reversal of tubal ligation;
iv) Any imaging related to the procedure is inclusive.

P10912 Transjugular liver/renal biopsy $350.00
Anes.Level 2

Notes:

i) Ultrasound guidance, venous puncture, central access catheter are included in the fee;
ii) Payable only for uncorrectable coagulopathy;
iii) The first biopsy is payable at 100%, the second and third at 50% up to a maximum of three per patient per day;
iv) If repeated within 6 months, payable at 50%;
v) Interventional Radiology consultation and payable.

P10905 Cerebral intra-arterial thrombolysis $1,168.24
Anes.Level 5

Notes:

i) Payable once only, regardless of number of arterial territories treated.
ii) Includes all diagnostic and superselective angiograms performed during procedure and immediate post procedure CT scans.
iii) Interventional radiology consultation not payable in addition.

Dermatology

Amendment

The cancellation date of the following provisional item has been extended. This will expire on December 31, 2007 or when replaced by a subsequent Minute, whichever occurs first:

P00228 Photo epilation of facial hair – per ¼ hour (or major portion thereof) $27.88

Notes:

i) Billable to a maximum of ½ hour per session
ii) Epilation of facial hair for familial hirsutism is not a benefit of the Plan
iii) Pre-authorization is required (see Preamble B.16.2 (6))

Ophthalmology

Amendment

The cancellation dates of the following provisional items have been extended, they will expire on June 30, 2007 or when replaced by a subsequent Minute whichever occurs first:

P22067	Computerized retinal nerve fibre layer photography and neuro-retinal rim assessment (e.g.: Heidelberg, GDX)	$63.92
P22068	- professional fee	$12.28
P22069	- technical fee	$51.64

Notes:

i) Requires both qualitative and quantitative assessments.

ii) Includes examination of both eyes whether at one time or two separate visits.

iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.

The cancellation date of the following provisional item has been extended until December 31, 2007:

P22125	Photodynamic therapy for age-related wet macular degeneration - professional fee	$274.39

Note: Payable to Retinal Physicians certified in PDT treatment only.

Otolaryngology

New Fee Item

25100	Laser photocoagulation of hereditary hemorrhagic telangiectasia lesions of nasal cavities (HHT)	$426.33 Anes. Level 6

Notes:

i) Not payable with fee items 00907, 00908, 00909, 00235, 00236, 00237, 02303, 02317, 02318, 02341 and 02346.

ii) Includes payment for any and all HHT sites treated by laser. Not for use on external non-symptomatic lesions.

iii) Payable for treatment of one or both nasal cavities at the same sitting regardless of the number of lesions treated.

iv) Maximum of five subsequent procedures in a six (6) month period, otherwise support with a written letter.

Internal Medicine

New Fee Item

The following fee item will be monitored for the 12- month period following the implementation date:

P10708	Video Capsule endoscopy using M2A capsule – professional fee	$250.00

Notes:

i. Payable for gastrointestinal bleeding suspected to originate in the small intestine, and only after other investigations have been ruled out other causes.

ii. Limited to services rendered at St. Paul's Hospital, Vancouver only.

Amendment

The cancellation date of the following provisional items have been extended until December 31, 2007 or when replaced by a subsequent Minute:

Patient Activated Cardiac Event Recorders

P00362	Event/unmonitored loop recorders (first strip) – professional fee	$35.52
P00369	- each additional strip (per strip)	$17.76
	Note: Additional strips are limited to two extra strips per patient, per-two-week period.	
P00392	Event-unmonitored loop recorder – technical fee	$42.68

Notes:

i) The following notes apply to fee items 00362, 00369, 00392
ii) These items are intended to cover a two-week period
iii) Consultation not paid in addition
iv) Provide note record when more than one recording billed per patient, per year
v) Holter monitor not payable in addition
vi) An explanatory note is required for second test, same patient

Plastic Surgery

Amendment

The payment rate of the following fee item is hereby adjusted as indicated.

The Section reduced the consultation fee by $4.00 effective April 15, 2005, in order to fund a number of fee item changes. The consultation fee adjustment has been monitored for 12 months and as the documentation confirmed the Section contributed more funding than was required, an increase of $2.81 can be made to the consultation fee, retroactive to April 15, 2005 to correct the funding difference.

06010	Consultation to include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report.	$63.54

It is recommended that this Minute is accepted as the cost of the fee item changes were less than anticipated.

The cancellation date of the following provisional items has been extended and will expire on October 15, 2007 or when replaced by a subsequent Minute, whichever occurs first:

CP06159	TRAM Flap reconstruction of mastectomy defect	$1,000.00 Anes.Level 5

Notes:

i) Includes preparation of site to be grafted, harvesting and insertion of the graft, closure of donor defect, with or without mesh.
ii) Reconstruction of both breasts (bilateral) with <u>two</u> pedicled TRAM flaps is payable at 150%.

P61152	Abdominal panniculectomy – where medically indicated, secondary to chronic subpanus intertrigo, which has been unresponsive to a reasonable period of medical treatment	$292.68 Anes. .Level 4

Note: To include umbilicoplasty where medically indicated.

P61166	Mastopexy balancing unilateral (isolated procedure)	$313.79 Anes. Level 3
P61167	Mastopexy, balancing – when performed at same time as contralateral breast surgery	$235.34 Anes. Level 3
P61223	ORIF of phalangeal (middle or proximal) or metacarpal fracture *Note: Multiple fractures paid in accordance with Preamble B.10.a*	$261.00 Anes. Level 2
P61222	ORIF of phalangeal (middle or proximal) or metacarpal fracture	$191.35 Anes. Level 2

General Surgery

New Fee Item

The following new provisional fee item is effective April 1, 2006 and will be monitored for the 18 month period following the implementation date:

P07368	Laparoscopic splenectomy	$590.00 Anes. Level 6

Vascular Surgery

The following modifications to the Payment Schedule have been approved effective immediately:

Fee item 77043
Re-operation:
Re-dissection of artery/vein at site of previous anastomosis, arteriotomy or venotomy (after 21 days) – extra. Payable at 25% of listed fee for surgery performed.

Amendment to the Notes:
i. Payable once per side only.
ii. Not payable with fee items 77100, 77102, 77104 or 77112.

Radiology

Amendments

1. The following note is hereby added to the Radiology Sectional Schedule, subsequent to the heading "Interventional Radiology"

   Note: The following fees are specific to physicians' professional fees for the following services:

2. Note vii) subsequent to fee item P83000 (Interventional Radiology Consultant) is hereby modified as follows:

   vii) Payable if one of the following procedures is planned but cancelled subsequent to the consultation:
   a) Percutaneous nephrostomy (00978)
   b) Percutaneous nephrostomy with dilation of tract (00979)
   c) Transhepatic biliary drainage procedure (00980)

d) *Therapeutic radiological embolization (00981)*
e) *Percutaneous transluminal angioplasty (00982)*
f) *Percutaneous abdominal abscess drainage by catheter insertion (00983)*
g) *Embolization fee codes T00995, T00997, T00998;*
h) *Abdominal aortic aneurysm repair using endovascular stent graft – radiology component (P10900)*
i) *Complex diagnostic neuroangiography*

Deleted Fee Items

The following fee items are hereby deleted from the section of Diagnostic Radiology, effective November 1, 2006:

08612	Xeromammography – unilateral	$62.49
08613	Xeromammography – bilateral	$99.25

Amendment

The following anesthetic intensity and complexity levels for the indicated interventional Radiology fee items are hereby added as follows:

P10906	Image-guided percutaneous vertebroplasty – first level	$325.00 Anes.Level 4
P10907	- each additional level (to a maximum of 3)	$75.00 Anes.Level 4

Notes:
i) Payable only when rendered on in-patient or day-care basis in acute care facility;
ii) Payable for osteoporotic fractures only if conservative therapy shows no or minimal improvement after 4-6 weeks and pain remains incapacitating;
iii) Includes all associated diagnostic imaging, including post procedural CT scan necessary to complete the procedure;
iv) Interventional Radiology consultation not payable in addition.

P10904	Percutaneous transcatheter arterial chemo-embolization (TACE)	$325.00 Anes.Level 3

Notes:
i) Fee is per session/sitting, regardless of number of lesions treated;
ii) Includes all associated imaging necessary to complete procedure;
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P10908	Percutaneous image-guided tumour ablation – first lesion	$432.00 Anes.Level 3

Notes:
i) Payable only for non-resectable liver, kidney, lung tumours, colorectal metastases and osteoid osteoma;
ii) Payable to a maximum of 3 lesions treated at same session – 100% for first lesion, 75% for second lesion and 25% for third lesion;
iii) Includes all CT and ultrasound guidance necessary to complete the procedure;
iv) Paid at 50% if repeated within 30 days;
v) Interventional Radiology consultation is payable.

P10909	Percutaneous intravascular/intracorporeal medical device/foreign body removal	$350.00 Anes.Level 3

Notes:

i) All angiography, angioplasty and/or intravascular stenting included;

ii) If a second or third medical device /foreign body is removed, payable at 50% each, to a total maximum of three;

iii) Interventional Radiology consultation is not payable.

P10911	Selective salpingography/fallopian tube recanalization (FTR)	$350.00 Anes. Level 2

Notes:

i) Hysterosalalpinogram not payable in conjunction with the procedure;

ii) Paid at 2/3 of the fee if unilateral;

iii) FTR is not an insured benefit when used to correct scarring of the fallopian tubes after reversal of tubal ligation;

iv) Any imaging related to the procedure is inclusive.

P10912	Transjugular liver/renal biopsy	$350.00 Anes.Level 2

Notes:

i) Ultrasound guidance, venous puncture, central access catheter are included in the fee;

ii) Payable only for uncorrectable coagulopathy;

iii) The first biopsy is payable at 100%, the second and third at 50% up to a maximum of three per patient per day;

iv) If repeated within 6 months, payable at 50%;

v) Interventional Radiology consultation and payable.

P10905	Cerebral intra-arterial thrombolysis	$1,168.24 Anes.Level 5

Notes:

i) Payable once only, regardless of number of arterial territories treated.

ii) Includes all diagnostic and superselective angiograms performed during procedure and immediate post procedure CT scans.

iii) Interventional radiology consultation not payable in addition.

T00921	Varicocele and/or uterine artery embolization – unilateral	Anes. Level 3
T00925	Varicocele and/or uterine artery embolization – bilateral	Anes. Level 3

Notes:

i) Fee items P00921 and P00925 include all angiographies necessary to perform the procedure.

Laboratory Medicine

New Fee Item

The following fee item is added to the Section of Laboratory Medicine, effective June 2, 2006:

91635	Fecal elastase	$43.96

Note: Restricted to BC Children's and Women's Hospital Laboratory.

Deleted Fee Item

The following fee item is deleted from the Section of Laboratory Medicine, effective December 1, 2006:

91625	Faecal chymotrypsin	$24.62

Extensions

The cancellation dates of the following provisional items have been extended. This Minute will expire on December 31, 2007 or when replaced by a subsequent Minute, whichever occurs first:

Haematology:

P90027***	Activated Protein C Resistance (APCR)	$51.88
P90036**	Antiphosphatidylserine (IgG)	$30.03
P90037**	Antiphosphatidylserine (IgM)	$30.03
	Note: When both P90036 and P90037 performed on same specimen, second test is billable at $22.38.	
P90038***	Anti Saccharomyces Cerevisiae (ASCA) – IgA	$31.50
P90039***	Anti Saccharomyces Cerevisiae (ASCA) – IgG	$31.50
	Note: When both P90038 and P90039 are performed on same specimen, second test is billable at $25.11.	
P90042***	Anti-Xa Heparin assay	$115.01
P90045*	Bone marrow examination	$265.97
	Note: 90045 includes 90465, 90490, 90205, 90340 and 90210	
P90055***	Circulating inhibitor screen - unincubated simple mixing study	$37.32
P90065	Cold agglutinins – qualitative	$17.69
P90072**	Collagen Binding assay	$64.17
	Note: Not billable with 90505.	
P90073**	Dilute Russell Viper Venom Time	$31.33
P90075**	Differential cell count on body fluids other than blood	$12.72
90080	Direct antiglobulin (Coombs') test, polyspecific	$30.36
P90095**	Erythropoietin (EPO) assay	$36.08
P90127***	Factor V Leiden / PGM – 1st gene	$95.12
	Notes:	
	i) Restricted to Royal Columbian, Vancouver and Victoria General Hospitals	
	ii) Not billable for screening purposes	
	iii) Applicable to patients with thrombophilia.	
P90128***	Factor V Leiden / PGM – 2nd gene	$60.01
	Notes:	
	i) Billable only when performed with P90127	
	ii) Restricted to Royal Columbian, Vancouver and Victoria General Hospitals	
P90185	Glucose-6-phosphate dehydrogenase (G-6-PD) screening test	$21.35
P90240**	Haemoglobin electrophoresis	$38.60
P90290**	Immunophenotyping by flow cytometry - peripheral blood and/or tissue and/or bone marrow and/or body fluids - 5 tube panel	$266.23
P90335**	Malaria and other parasites	$23.20
P90340**	Marrow films for interpretation	$195.16
P90357	Neutrophil Oxidative Burst Assay	$137.83
P90360**	Nitro blue tetrazolium test	$37.21
P90377**	Phospholipid Neutralization Test – for confirmation of Lupus Anticoagulant	$52.25
P90390**	Platelet antibodies	$42.11
P90400	Platelet estimation on film	$5.67
P90427**	Protein S Activity (clot-based)	$46.82
	Note: Not billable with 90435 or 90430	

P90440	Prothrombin time/INR	$14.89
P90460+	RBC antibody detection, per tube (albumin, enzyme or other antibody enhancement, e.g. LISS additive)	$8.44
P90465	RBC morphology including platelet estimation	$8.44
P90470	Red cell folate	$39.74
P90510+	Saline tubes (per tube)	$9.28
P90525	Sickle cell identification	$30.90
P90530***	Stypven prothrombin time	$34.57
P90560***	Von Willebrand's multimer analysis by autoradiography	$108.49
P91160**	Antimyeloperoxidase Ab	$31.82
P91355	Cells, count - CSF and other fluids	$36.01

Microbiology:

P90605**	Anaerobic culture investigation	$14.55
P90610***	Smear for inclusion bodies	$40.23
P90615**	Antibiotic susceptibility test, semi-quantitative per organism	$19.24
P90620	Biochemical identification of micro-organism- per organism	$11.80
P90625**	Blood culture, using aerobic and/or anaerobic media	$42.99
P90651	Chlamydia trachomatis using NAT – urine	$32.99
P90652	Chlamydia trachomatis using NAT – urogenital swab	$32.06
P90665**	Fungus culture	$16.73
P90730	Smear for inclusion bodies	$15.05
P90740	Stained smear	$7.25
P90750	Biochemical identification of micro-organism in stool	$14.21
P90780**	Throat or nose culture - each additional culture	$6.18
P90785	Trichomonas and/or candida, direct examination	$5.49
P90795	Examination for pinworm ova	$5.76
P90815	Serological tests - 1 to 3 antigens	$31.23
P90820	Serological tests - 4 or more antigens *Note: Not to be billed for any virology testing where specific listings exist (e.g.: Hepatitis).*	$46.41
P90825***	Smear or section for electron microscopy	$33.98
P90830	Virus isolation	$55.82
P91023**	Acetyl CoA: a-glucosaminide-N-acetyl transferase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P91027**	Acid Lipase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91036***	ACTH stimulation test	$53.27
P91037**	Acylcarnitine profiling *Note: Restricted to BC Children's Hospital.*	$50.45
P91096**	Alpha-iduronidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91097**	Alpha-mannosidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91120***	Amniotic fluid, bilirubin scan	$64.89
P91142**	Anti-diuretic hormone (ADH), plasma	$111.26
P91155*	Antiglomerular basement membrane antibody	$31.82
P91162	Anti-tissue transglutaminase antibodies (anti-TTG), IgA *Note: Not billable with 91800.*	$29.90
P91180***	Apoprotein E genotyping	$75.55
P91231**	Beta-glucuronidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91232**	Beta-mannosidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64

P91330	Calculus analysis – urine	$34.45
P91380**	Cholinesterase with dibucaine number	$37.00
P91386***	Chromatography - keto acids	$44.38
P91387***	Chromatography - reducing substances-urine	$38.37
P91388***	Chromatography - thin layer (T.L.C.)	$39.91
P91395	Complement, total haemolytic (CH 100)	$54.04
P91480	Acetazolamide	$56.86
P91484	Amikacin	$56.86
P91486	Amiodarone	$56.86
P91490	Amoxapine	$56.86
P91492	Chlorpromazine	$56.86
P91496	Clobazam	$60.89
P91498	Clomipramine	$60.89
P91500	Clonazepam	$56.86
P91508	Desmethylclobazam	$56.86
P91510*	Diazepam	$56.86
P91512	Disopyramide	$56.86
P91514	Doxepin	$56.86
P91516	Fluoxetine	$56.86
P91518	Flupenthixol	$56.86
P91520	Fluphenazine	$56.86
P91522	Fluvoxamine	$56.86
P91526	Haloperidol	$56.86
P91528	Imipramine	$56.86
P91530	Lidocaine	$54.66
P91532*	Lorazepam	$56.86
P91534	Loxapine	$56.86
P91536	Maprotiline	$56.86
P91538	Methotrexate	$56.25
P91540	Methotrimeprazine	$56.86
P91542	Methylphenidate	$56.86
P91544	N-Acetyl procainamide	$56.86
P91546	Netilmicin	$56.86
P91548	Nitrazepam	$56.86
P91552	Paroxetine	$56.86
P91554	Perphenazine	$56.86
P91556	Procainamide	$56.86
P91558	Propranolol	$56.25
P91560*	Sertraline	$56.86
P91562	Thioridazine	$56.86
P91566	Trazodone	$56.86
P91568	Trifluoperazine	$56.86
P91570	Trimipramine	$56.86
P91601**	Electrophoresis - protein, quantitative	$33.25
P91602**	Electrophoresis - C.S.F	$38.59
P91680	Gastric analysis, intubation	$22.17
P91715***	Glucose quantitative, 2 to 5 hours	$36.65
P91717**	Glucose quantitative – intravenous	$47.54
P91730	Glutathione peroxidase	$52.20
P91762**	Heparan sulfamidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P91777**	Hexosaminidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P91800	IgA Anti-gliadin antibodies *Note: Applicable only to TTG negative gluten sensitive enteropathy*	$39.83
P91820***	Immunofixation – CSF	$124.04

P91850	Inclusion bodies - (cytomegalic) – urine	$9.51
P91912	Lead - prophyrin screening test – urine	$7.60
P91915***	Lecithin sphingomyelin ratio	$273.52
P91920***	LHRH stimulation test - in addition to specific tests billed	$56.48
P91940**	Lipoprotein electrophoresis	$68.49
P91970	Metachromatic granules – urine	$18.34
P91992	Mitochondrial preparation – muscle *Note: Restricted to BC Children's Hospital.*	$110.67
P91997**	N-acetyl-Galactosamine-6-sulfate sulfatase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P92035	Pentagastrin test – gastric	$82.50
P92075	Pigments, abnormal, (spectroscopic)	$17.18
P92090	Porphyrins - qualitative, urine	$9.43
P92091	Porphyrins - quantitative with separation – urine	$67.63
P92095**	Porphyrins - quantitative – blood	$26.92
P92110	Pregnancy Test – Serum	$10.14
P92146	Proteins - timed urine collection	$10.96
P92156**	Pyruvate Carboxylase, Fibroblasts *Note: Restricted to BC Children's Hospital.*	$114.53
P92157**	Pyruvate Dehydrogenase, fibroblasts *Note: Restricted to BC Children's Hospital.*	$114.53
P92195**	Respiratory chain enzymes – muscle *Notes:* *i) Includes Complex 1, Complex II, Complex IV, citrate synthase* *ii) Restricted to BC Children's Hospital.*	$335.53
P92201	Salicylates, qualitative – gastric	$3.54
P92202	Salicylates, qualitative – urine	$3.67
P92320***	Thyroid Releasing Hormone (TRH) Stimulation Test *Note: Includes all time spent with patient, including injection and medication administered.*	$68.33
P92346**	Transferrin Isoelectric focusing (qualitative) *Note: Restricted to BC Children's Hospital.*	$110.59
P92353**	13C Triolein Breath Test for malabsorption *Note:* *i) Includes collection of "before" and "after" breath samples* *ii) Not billable with 91636* *Note: Restricted to BC Children's Hospital.*	$82.97
P92395	Urinalysis, microscopic	$5.89
P92430*	Vitamin A	$56.38
P92435*	Vitamin B1	$66.36
P92440*	Vitamin B2	$66.36
P92445*	Vitamin B6	$66.36
P92465	Vitamin E	$63.53
P92467	White blood cell preparation for lysosomal enzyme testing	$51.76
P92470**	Xylose tolerance	$129.72

Anatomical:

P93010	Crystal identification, synovial fluid	$41.11
P93070***	Chromosomal breakage studies	$214.10
P93085	Cytologic preparation and examination of fine needle aspirate	$112.30
P93090	Cytologic preparation and interpretation of pre-screened, non-gynaecological cytology	$78.10
P93095	Cytologic preparation and interpretation of unscreened, non-gynaecological cytology	$101.90
P93100*	Electron microscopy fee	$458.06

Nuclear Medicine:

P09817	Receptor Imaging - Isolated Procedure	$235.77
P09826	Tumour imaging - isolated procedure	$1265.13
P09870	Ocular tumour localization	$164.92
P09871	Brain scan - regional cerebral blood flow (isolated procedure)	$239.95
P09880	Treatment for hyperthyroidism or cardiac disease - charge per course of treatment (Iodine therapy)	$205.41
P09881	Treatment for polycythaemia vera with P32 - charge per course of treatment	$205.41
P09883	Treatment for prostate cancer - charge per course of treatment	$414.88
P09884	Treatment for metastatic carcinoma of bone - charge per ourse of treatment	$269.74
P09885	Treatment for ascites and/or pleural effusion, malignant	$403.91
P09898	Coronary perfusion with radio particles, per radionuclide	$175.74

Medical Microbiology:

P94005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums)	$104.76
P94010	Consultation: to consist of examination, review of history and laboratory findings with a written report	$117.83
P94012	Repeat or limited consultation: where a consultation for same illness is repeated within six (6) months of the last visit by the consultant or where, in the judgement of the consultant, the consultative service does not warrant a full consultative fee	$65.47
P94006	Directive care	$26.19
P94007	Subsequent office visit	$26.19
P94008	Subsequent hospital visit	$26.19
P94009	Subsequent home visit	$52.43

Amendment

The following note is hereby added to the indicated fee item, effective January 1, 2007:

92280	Thyroglobulin	$34.12

Note: Primary use is a tumor marker for thyroid cancer. Non-neoplastic conditions where thyroglobulin measurement may be useful are thyrotoxicosis factitia, congenital hypothyroidism and inflammatory thryoiditis.

The following note is hereby deleted from the indicated fee item, effective January 1, 2007:

92285*	Thyroglobulin antibodies	$24.94

Note: Payable only when performed with 92280.

The following note is hereby added to the indicated fee item, effective January 1, 2007:

92285*	Thyroglobulin antibodies	$24.94

Note: Thyroglobulin antibodies should only be performed as an adjunct to thyroglobulin measurement for the conditions listed under fee item 92280.

BRITISH COLUMBIA
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Name Change and Fee Description Wording Modified for Fee Items 14015 and 14016

As part of the 2006 Working Agreement, the General Practice Services Committee (a joint committee of the B.C. Ministry of Health, the B.C. Medical Association, and the Society of General Practitioners of B.C.) has developed a number of initiatives in support of full service family practice. The name change and fee description wording for fee items 14015 and 14016 is modified as follows:

FACILITY PATIENT CONFERENCE FEE:

Fee item and description:

14015 General Practice Facility Patient Conference: when requested by a facility to review ongoing management of the patient in that facility or to determine whether a patient in a facility with complex supportive care needs can safely return to the community or transition to a supportive care or long-term care facility
- per 15 minutes or greater portion thereof..... $40.00

Notes:

i) *Refer to Table 1 below for eligible patient populations.*

ii) *Must be performed in the facility and results of the conference must be recorded in* the patient chart.

iii) *Payable only for patients in a facility. Facilities limited to: hospital, palliative care facility, LTC facility, rehab facility, assisted living, sub-acute facility, psychiatric facility, detox/drug and alcohol facility, community placement agency, disease clinic (DEC, arthritis, CHF, asthma, cancer or other palliative diagnoses, etc).*

iv) *Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, social workers, CDM nurses, any healthcare provider charged with coordinating discharge and follow-up planning.*

v) *Requires interdisciplinary team meeting of at least 2 health professionals in total, and will include family members when available.*

vi) *Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.*

vii) *Claim must state start and end times of the service.*

viii) *If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*

ix) *Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*

x) *Not payable on the same day for the same patient as the Community Patient Conference Fee (14016).*

xi) *Visit payable in addition if medically required and does not take place concurrently with the patient conference. Medically required visits performed consecutive to the Facility Patient Conference are payable.*

This fee is for patient care conferences taking place in a facility.

Eligibility:
This incentive payment is available to improve patient care to:

- All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00). Practitioners who have billed any speciality fee in the previous 12 months are not eligible; and
- Whose majority professional activity is in full service family practice as described in the introduction; and
- Is considered the most responsible GP for that patient at the time of service.
- This payment is billable for the groups of patients identified in Table 1 (attached).

1. How do I claim the Facility Patient Conference Fee payments?

Submit the new fee item 14015 (value $40 for each 15 minute unit or major portion thereof) through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders (See Table 1).

2. What is the maximum number of payments allowed per patient?

A maximum of four units (60 minutes) per day, to a maximum of 6 units (90 minutes) per calendar year.

3. Is this payment eligible for rural premiums?

Yes.

4. Are there circumstances where payment will be allowed even if the care conference did not occur in a face-to-face meeting in the facility?

Face to face meetings are expected. Only under exceptional circumstances will care conferences by teleconference be payable. For audit purposes, when this occurs, a chart entry is required to indicate that you were not physically present and the circumstances that prevented it.

5. If more than one patient is discussed at the same case management conference is the fee billable for each patient discussed?

Yes. The fee is billable under the PHN of each of the patients discussed, for the length of time that each patient's care was discussed. Concurrent billing for more than one patient is not permitted. That is, if you attend a care conference and two patients are discussed over the course of an hour the total time billed must not exceed one hour.

6. Is the Facility Patient Conference Fee billable by physicians who are employed or under contract to a facility and would have attended the conference as a requirement of their employment or contract with the facility?

No.

7. Is the Facility Patient Conference Fee billable by physicians working in a or working under salary, service contract or sessional arrangements?

No. Physicians working under these funding arrangements are paid a set amount for their time, and therefore would not qualify for this payment.

8. Can this fee be billed if I also submitted a Community Patient Conference Fee on the same day?

No. It is not payable on the same day of service for the same patient as the Community Patient Conference Fee. The Community Patient Conference Fee is intended for patients living in the community while the Facility Patient Conference Fee is intended for patients in a facility.

If a Community Patient Conference Fee was billed and the patient is subsequently admitted to a facility and a patient management conference is requested by that facility, fee item 14015 may be billed. Conversely, if a Facility Patient Conference Fee is billed and the patient is subsequently discharged from the facility and additional clinical action planning is required, fee item 14016 may be billed. They may not, however, be billed on the same calendar day.

9. Are locums able to bill this bonus?

Yes. Locum coverage is considered part of the usual care provided by the host general practitioner.

10. Can I bill for patients covered by other provinces?

No. This service is not covered under the reciprocal agreement with other provinces.

11. Is this fee billable by hospitalists or on behalf of hospitalists?

No. Refer to bullet ix under the fee description above. Hospitalists are under contract to a facility and would have attended the conference as part of their duties.

12. Can a community-based GP bill this fee for the discharge planning of a patient from an acute-care hospital?

This fee does not cover routine discharge planning from an acute-care facility, nor is this fee payable for conferencing with acute-care nurses on the patient's ward. The fee description above stipulates:

> *iv) "Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, social workers, CDM nurses, any healthcare provider charged with coordinating discharge and follow-up planning."*

If a patient's diagnosis is covered under the restrictions of this fee and the condition is sufficiently complex to warrant a discharge conference with the above care providers, the GP's attendance at this conference is payable under this fee item—provided the GP is not employed by or under contract to the facility and would otherwise have attended the conference as a requirement of their employment or contract with the facility; or working under salary, service contract or sessional arrangements.

Table 1: Eligible Patient Populations for the Facility Patient Conference Fee and the Community Patient Conference Fee

i. Frail elderly (ICD-9 code V15)

Patient over the age of 65 years with at least 3 of the following factors:

- Unintentional weight loss (10 lbs in the past year)
- General feeling of exhaustion
- Weakness (as measured by grip strength)
- Slow gait speed (decreased balance and motility)
- Low levels of physical activity (slowed performance and relative inactivity)
- Incontinence
- Cognitive impairment

ii. Palliative care (ICD-9 code V58)

Patient of any age who:

- Are living at home ("Home" is defined as wherever the person is living, whether in their own home, living with family or friends, or living in an assisted living residence or hospice); and
- Have been diagnosed with a life-threatening illness or condition; and
- Have a life expectancy of up to six months, and
- Consent to the focus of care being palliative rather than treatment aimed at cure.

iii. End of life (ICD-9 code V58)

Patients of any age:

- Who have been told by their physician that they have less than six months to live; or
- With terminal disease who wish to discuss end of life, hospice or palliative care.

iv. Mental illness

Patients of any age with any of the following disorders are considered to have mental illness:

- Mood Disorders
- Anxiety and Somatoform Disorders
- Schizophrenia and other Psychotic Disorders
- Eating Disorders
- Substance Use Disorders
- Infant, Child and Adolescent Disorders
- Delirium, Dementia and Other Cognitive Disorders
- Personality Disorders
- Developmentally Delayed, Fetal Alcohol Spectrum Disorders and Autism Spectrum Disorders
- Sexual Dysfunction
- Dissociative Disorders
- Mental Disorders due to a General Medical Condition
- Factitious Disorder

Definitions and the management of these mental disorders are defined in the Manual: Management of Mental Disorders, Canadian Edition, Volume One and Two, edited by Dr. Elliot Goldner, Mental Health Evaluation and Community Consultation Unit, University of British Columbia. Definitions for Delerium, Dementia and Other Cognitive Disorders; Developmental Disabilities; Dissociative Disorders; Mental Disorders due to a General Medical Condition and Factitious Disorder are found in the Diagnostic and Statistical Manual of Mental Disorders - DSM-IVR.

v. Patients of any age with multiple medical needs or complex co-morbidity
Patient of any age with multiple medical conditions or co-morbidities (two or more distinct but potentially interacting problems) where care needs to be coordinated over a period of time between several health disciplines. On your claim form use the code for one of the major disorders (On April 1, 2007 it is expected that codes for all three main disorders will be required).

COMMUNITY PATIENT CONFERENCE FEE

Fee item and description:

14016 General Practice Community Patient Conference Fee: Creation of a coordinated clinical action plan for the care of **community-based patients** with more complex needs. Payable only when coordination of care and two-way collaborative conferencing with other health care providers is required (e.g., specialists, psychologists or counsellors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry). As well as with the patient and possibly family members (as required due to the severity of the patients condition).

- per 15 minutes or greater portion thereof..... $40.00

Notes:

i) Refer to Table 1 for eligible patient populations.

ii) Fee includes:

a) The interviewing of patient and family members as indicated and the conferencing with other health care providers as described above -- this does not require face-to-face interaction in all case; and;

b) As appropriate, interviewing of, and conferencing with patients, family members, and other community health care providers; organizing and reviewing appropriate laboratory and imaging investigations, administration of other types of testing as clinically indicated (e.g., Beck Depression Inventory, MMSE, etc); provision of degrees of intervention or No CPR documentation; and

c) The communication of that plan to patient, other health care providers, and family members or others involved in the provision of care, as appropriate; and

d) The care plan must be recorded in the chart and include the following information:

1) Patient's Name

2) Date of Service

3) Diagnosis:

a) V15 (Frail Elderly)

b) V28 (Palliative/End of Life Care)

c) Mental Illness (enter ICD-9 code of qualifying illness)

d) Patients of any age with multiple medical needs or complex co-morbidity (enter ICD-9 for one of the major disorders)

4) Reason for need of Clinical Action Plan

5) Health Care Providers with whom you conferred & their role in provision of care

6) Clinical Plan Determined, including tests ordered and/or administered

7) Patient risks based on assessment of appropriate domains (list of co-morbidities and safety risks)

8) List of priority interventions that reflect patient goals for treatment

9) *What referrals will be made, what follow-up has been arranged (including timelines and contact information), as well as advanced planning information*
10) *Start and stop times of service*

iii) *Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.*

iv) *Claim must state start and end times of service.*

v) *Not payable to the same patient on the same date of service as the Facility Patient Conference fee (fee item 14015).*

vi) *Not payable to physicians who are employed by, or who are under contract to a facility, who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*

vii) *Visit payable in addition if medically required and does not take place concurrently with clinical action plan.*

Eligibility:
This incentive payment is available to improve patient care to:

- All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00), except those with access to any specialty consultation fee; and
- Whose majority professional activity is in full service family practice as described in the introduction;
- Is considered the most responsible general practitioners for that patient at the time of service; and
- Where the severity of the patient's condition justifies the development of a clinical action plan.

This fee compensates family physicians for the creation of a coordinated clinical action plan for the care of community-based patients identified in Table 1. The clinical action plan fee depends not on the diagnosis alone, but rather the severity of the problems. As such, the fee is billable only when case conferencing and collaborative planning with other health care providers is required (e.g., specialists, psychologists or counsellors, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry) as well as with the patient and possibly family members, in order to develop the clinical action plan.

1. How do I claim the Community Patient Conference Fee payments?

Submit the new fee item 14016 (value $40 for each 15 minute unit or major portion thereof) through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders (See Table 1), and the chart entry must contain the elements specified in section ii(d) of the fee description above.

2. What is the maximum number of payments allowed per patient?

A maximum of four units (60 minutes) per day, to a maximum of 6 units (90 minutes) per calendar year.

3. Is this fee billable if a claim for the Facility Patient Conference Fee was also made for the patient on the same day?

No.

4. Is this payment eligible for rural premiums?

Yes.

5. Are locums able to bill this bonus?

Yes. Locum coverage is considered part of the usual care provided by the host general practitioner.

6. Can I bill for patients covered by other provinces?

No.

7. Is the Community Patient Conference Fee billable by physicians working under salary, service contract or sessional arrangements.

No. Physicians working under these funding arrangements are paid a set amount for their time, and therefore would not qualify for this payment.

8. Am I eligible to bill this fee when I refer an acutely-ill patient and discuss the case with an Emergency Room Physician/Specialist/Emergency Department nurse?

No. This fee covers the two-way collaborative conferencing with other providers in the development of a clinical action plan. The transmission of information in a referral process does not qualify.

Questions or Comments?

B.C. Ministry of Health
Phone (250) 952-3124 Fax 1 800 952-2895

B.C. Medical Association
Greg Dines
Phone (604) 638 -2807 or 1 800 665-2262

Society of General Practitioners of B.C.
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Table 1: Eligible Patient Populations for the Facility Patient Conference Fee and the Community Patient Conference Fee

i. Frail elderly (ICD-9 code V15)

Patient over the age of 65 years with at least 3 of the following factors:

- Unintentional weight loss (10 lbs in the past year)
- General feeling of exhaustion
- Weakness (as measured by grip strength)
- Slow gait speed (decreased balance and motility)
- Low levels of physical activity (slowed performance and relative inactivity)
- Incontinence
- Cognitive impairment

ii. Palliative care (ICD-9 code V58)

Patient of any age who:

- Are living at home ("Home" is defined as wherever the person is living, whether in their own home, living with family or friends, or living in a supportive living residence or hospice); and
- Have been diagnosed with a life-threatening illness or condition; and
- Have a life expectancy of up to six months, and
- Consent to the focus of care being palliative rather than treatment aimed at cure.

iii. End of life (ICD-9 code V58)

Patients of any age:

- Who have been told by their physician that they have less than six months to live; or
- With terminal disease who wish to discuss end of life, hospice or palliative care.

iv. Mental illness

Patients of any age with any of the following disorders are considered to have mental illness.

- Mood Disorders
- Anxiety and Somatoform Disorders
- Schizophrenia and other Psychotic Disorders
- Eating Disorders
- Substance Use Disorders
- Infant, Child and Adolescent Disorders
- Delirium, Dementia and Other Cognitive Disorders
- Personality Disorders
- Developmentally Delayed, Fetal Alcohol Spectrum Disorders and Autism Spectrum Disorders
- Sexual Dysfunction
- Dissociative Disorders
- Mental Disorders due to a General Medical Condition
- Factitious Disorder

Definitions and the management of these mental disorders are defined in the Manual: Management of Mental Disorders, Canadian Edition, Volume One and Two, edited by Dr. Elliot Goldner, Mental Health Evaluation and Community Consultation Unit, University of British Columbia. Definitions for Delerium, Dementia and Other Cognitive Disorders; Developmental Disabilities; Dissociative Disorders; Mental Disorders due to a General Medical Condition and Factitious Disorder are found in the Diagnostic and Statistical Manual of Mental Disorders - DSM-IVR.

v. Patients of any age with multiple medical needs or complex co-morbidity
Patient of any age with multiple medical conditions or co-morbidities (two or more distinct but potentially interacting problems) where care needs to be coordinated over a period of time between several health disciplines. On your claim form use the code for one of the major disorders (On April 1, 2007 it is expected that codes for all three main disorders will be required).

Example #1:
Mr. B, 73 years old, arrives for his office visit accompanied by his two children. They are concerned that, since his wife's death a year ago, he has deteriorated significantly. The house is dirty and his personal hygiene has slipped. He is not eating and has lost weight, and is drinking more than he used to. He is no longer as interested in his family's activities and, on occasion, he has forgotten the names of his grandchildren. You initially meet with all three, then you excuse the daughters and meet alone with Mr. B. He is unkempt, his clothes hang on his body, and he doesn't engage in conversation with you as he did in the past. He admits to drinking 'at least' a bottle of wine per day, and frequently comments that he wished he had died before his wife. You perform a full physical examination, without significant findings. You order laboratory investigations. At this point you also personally administer a Beck Depression Inventory and a Mini-Mental Status Examination, which reveals severe depression and mild cognitive impairment. You then meet with the patient and, with his permission, his children and discuss your findings and plan; Mr. B tells you to follow up with his children as his memory "hasn't been so good." Following this, through the course of the day you conference with (depending on your community) the Quick Response Team/ Geriatric Outreach/ Home Care Nurse to arrange for a home visit assessment, and also conference with a psychiatrist to discuss initiation of treatment and arrange for him to be seen. You phone his pharmacist to prescribe the antidepressant agreed upon during the telephone conference with the psychiatrist and to arrange for all his medications to be blister-packed as he has been forgetting to take them. You then phone his daughter to advise her of the steps taken and the appointments you have made for him, and arrange a follow-up office visit in two weeks.

Billing:
You are eligible in this case to bill 17101 for the full physical examination. You are also eligible to bill the appropriate units of 14016 for the time following the examination spent administering the Beck and MMSE, and organizing the care plan with other health care providers and with the patient and family.

Example #2:
Mr Y, whose wife has an aggressive recurrence of ovarian cancer,
phones to say that she has had a horrible night with pain, and with vomiting induced by the analgesic prescribed on her recent office visit. You talk to your patient Mrs. Y, who is now reluctantly willing to agree to a DNR. You conference with the doctor on

call for Palliative Care, or your local colleague who has special skills in this field, then arrange for the Palliative Care Nurse/Home Care Nurse to visit and initiate the treatment plan established and to arrange for the completed "No CPR" form to be picked up and added to Mrs. Y's home chart. Another phone call to the pharmacist is required to prescribe the necessary medications and arrange for them to pick up the triplicate on their delivery run.

Billing:
No visit occurred, but you are still eligible to bill the appropriate number of units of 14016 for the time spent conferencing with other providers and organizing your patient's care plan.

Example #3*:*
Kay, a 28-yr old woman, is brought to your office with her mother after a long disappearance. She has been living on the streets again and has been using a wide variety of street drugs. She wants to 'get off them', and is already entering withdrawal. You discuss options with her. You conference with one of the local Drug and Alcohol Centre's counselors and develop a plan for how to handle her care until a detox bed becomes available in 3-5 days. You arrange for the appropriate laboratory testing/screening. You arrange with Kay's pharmacist for daily pickups of her medications.

Billing:
You are entitled to bill for a visit fee for Kay, and eligible to bill the appropriate number of 14016 units for the time spent in conferencing with the other providers and for developing her clinical action plan.